2015 Medicare Physician Fee Schedule Proposed Rule
Summary of Payment Policy Proposals

The Centers for Medicare and Medicaid Services (CMS) released the review copy of the 2015 Medicare Physician Fee Schedule (MPFS) proposed rule on July 3, 2014. The American College of Radiology (ACR) will be submitting comments to CMS addressing issues of concern by the deadline in early September. Following are highlights of the proposed rule.

A. Multiple Procedure Payment Reduction (MPPR)

In the proposed rule, CMS did not propose any new policy change on MPPR.

B. Conversion Factor and Impacts (page 543)

The calendar year (CY) 2014 conversion factor (CF) is $35.8228. The Protecting Access to Medicare Act of 2014 (PAMA) replaced the reduction in the MPFS update that would otherwise occur on January 1, 2015 with a zero percent update from January 1, 2015 to March 31, 2015. CMS estimates that, based upon the zero percent update and the adjustments necessary to maintain budget neutrality for the policies in the proposed rule, the CF for this period will be $35.7977. In the absence of further Congressional action, the applicable update for the remainder of the year will be based on the statutory sustainable growth rate (SGR) formula and would be approximately -20.9%.

CMS states that the actual values used to compute physician payments for CY 2014 will be based on later data and are scheduled to be published by November 1, 2014 as part of the MPFS final rule. CMS also points out that while the Congress has provided temporary relief from negative updates every year since 2003, a long-term solution is critical.

Below is an excerpt from Table 60 on page 546: CY MPFS Proposed Rule Estimated Impact on Total Allowed Charges by Specialty (using the conversion factor for January 1-March 31st as mandated by the PAMA).

Specialty	Impact of Work and Malpractice RVU Changes	Impact of Practice Expense RVU Changes	Combined Impact
Radiology	0%	-1%	-2%
Interventional Radiology	0%	-1%	-1%
Nuclear Medicine	0%	0%	1%
Radiation Oncology	0%	-4%	-4%
Radiation Therapy Centers	0%	-8%	-8%

CMS explains that the most widespread specialty impacts in practice expense (PE) relative value units (RVUs) are generally related to the proposal to implement the Relative Value Update Committee (RUC) recommendation regarding the film-to-digital migration of imaging inputs, which primarily affects portable x-ray suppliers, diagnostic testing facilities, and interventional radiology. Radiation oncology and radiation treatment centers are negatively impacted by the proposal to treat radiation treatment vaults as indirect PE rather than direct PEs.

C. Inputs for Digital Mammography Services (Page 52)

CMS notes that mammography services are currently being reported and paid for using both CPT codes (for analog) and the CMS established G-codes (for digital). Given the RUC recommendation that all imaging codes, including mammography, be valued using digital rather than film inputs and a CMS review of Medicare claims data showing that the mammography CPT codes are billed extremely infrequently, CMS is proposing to delete the mammography G-codes beginning for CY 2015 and pay all mammography using the CPT codes. Additionally, because the CPT codes have not been recently reviewed and significant technological changes have occurred during this time, CMS is proposing to value the CPT codes using the RVUs previously established for the G-codes. CMS is also proposing these codes as potentially misvalued and requesting that the RUC and other interested stakeholders review these services in terms of appropriate work RVUs, work time assumptions and direct PE inputs.

D. Potentially Misvalued Services Under the Physician Fee Schedule (Page 67)

1. Validating RVUs of Potentially Misvalued Codes (Page 73)

a. CMS contracted with the Urban Institute to collect time data from several practices for services selected by the contractor in consultation with CMS. These data will be used to develop time estimates for MPFS services. Objective time estimates collected by the

Urban Institute will be compared to the current time values used in the fee schedule. The project team will then convene groups of physicians from a range of specialties to review the new time data and their potential implications for work and the ratio of work to time. In its efforts to collect primary data on the time involved in MPFS services, the Urban Institute has encountered numerous challenges. An interim report, Development of a Model for the Valuation of Work Relative Value Units, discusses the challenges encountered in collecting objective time data and offers some thoughts on how these can be overcome. This interim report is on the CMS website at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/RVUs-Validation-Urban-Interim-Report.pdf.

b. CMS also has a second contract with the RAND Corporation, which is using available data to build a validation model to predict work RVUs and the individual components of work RVUs, time, and intensity. CMS anticipates a report from this project by the end of the year and will make the report available on the CMS website.

2. CY 2015 Identification and Review of Potentially Misvalued Services (Page 74)

a. Public Nomination of Potentially Misvalued Codes

Two codes were nominated during the 2014 MPFS Final Rule comment period. Neither of these codes are typically billed by radiologists, nuclear medicine physicians or radiation oncologists.

b. Potentially Misvalued Codes – Review of High Expenditure Services

CMS is proposing the codes listed in Table 10 (below) as potentially misvalued codes as a prioritized subset of codes of the newly established statutory category, "codes that account for the majority of spending under the fee schedule."

TABLE 10: Proposed Potentially Misvalued Codes Through High Expenditure Specialty Screen

HCPCS	**Short Descriptor**	HCPCS	**Short Descriptor**
11100	Biopsy skin lesion	76775	Us exam abdo back wall lim
11101	Biopsy skin add-on	77263	Radiation therapy planning
11730	Removal of nail plate	77334	Radiation treatment aid(s)
11750	Removal of nail bed	78452	Ht muscle image spect mult
14060	Tis trnfr e/n/e/l 10 sq cm/<	88185	Flowcytometry/tc add-on
17110	Destruct b9 lesion 1-14	91110	Gi tract capsule endoscopy
31575	Diagnostic laryngoscopy	92136	Ophthalmic biometry
31579	Diagnostic laryngoscopy	92250	Eye exam with photos
36215	Place catheter in artery	92557	Comprehensive hearing test
36475	Endovenous rf 1st vein	93280	Pm device progr eval dual
36478	Endovenous laser 1st vein	93306	Tte w/doppler complete
36870	Percut thrombect av fistula	93351	Stress tte complete
51720	Treatment of bladder lesion	93978	Vascular study
51728	Cystometrogram w/vp	94010	Breathing capacity test
51798	Us urine capacity measure	95004	Percut allergy skin tests
52000	Cystoscopy	95165	Antigen therapy services
55700	Biopsy of prostate	95957	Eeg digital analysis
65855	Laser surgery of eye	96101	Psycho testing by psych/phys
66821	After cataract laser surgery	96118	Neuropsych tst by psych/phys
67228	Treatment of retinal lesion	96372	Ther/proph/diag inj sc/im
68761	Close tear duct opening	96375	Tx/pro/dx inj new drug addon
71010	Chest x-ray 1 view frontal	96401	Chemo anti-neopl sq/im
71020	Chest x-ray 2vw frontal&latl	96409	Chemo iv push sngl drug
71260	Ct thorax w/dye	97032	Electrical stimulation
73560	X-ray exam of knee 1 or 2	97035	Ultrasound therapy
73562	X-ray exam of knee 3	97110	Therapeutic exercises
73564	X-ray exam knee 4 or more	97112	Neuromuscular reeducation
74183	Mri abdomen w/o & w/dye	97113	Aquatic therapy/exercises
75978	Repair venous blockage	97116	Gait training therapy
76536	Us exam of head and neck	97140	Manual therapy 1/> regions
76700	Us exam abdom complete	97530	Therapeutic activities
76770	Us exam abdo back wall comp	G0283	Elec stim other than wound

c. Epidural and Fluoroscopic Guidance – CPT codes 62310, 62311, 62318, 62319, 77001, 77002 and 77003

For CY 2014, CMS established interim final values for four epidural injection procedures.

- CPT codes 62310 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic)
- 62311 (Injection(s), of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, including needle or catheter placement, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal))
- 62318 (Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; cervical or thoracic)
- 62319 (Injection(s), including indwelling catheter placement, continuous infusion or intermittent bolus, of diagnostic or therapeutic substance(s) (including anesthetic, antispasmodic, opioid, steroid, other solution), not including neurolytic substances, includes contrast for localization when performed, epidural or subarachnoid; lumbar or sacral (caudal)).

These interim final values resulted in CY 2014 payment reductions from the CY 2013 rates for all four procedures.

After reviewing thousands of comments objecting to the interim final values for the codes, CMS believes that they need to reassess their valuation of the codes and requires additional information in order to do so. CMS notes that the epidural codes are frequently billed with imaging guidance in both the facility and non-facility settings. Based on the frequency with which these codes are reported with fluoroscopic guidance codes, it appears that fluoroscopic guidance is both typically used and typically reported separately in conjunction with the epidural injection services.

CMS notes that other injection procedures, including some recommended by commenters for use as a reference in valuing these epidural injection codes, include the work and PEs of image guidance in the injection code. Therefore, CMS believes it would be appropriate for the injection and imaging guidance codes to be bundled and the inputs for image guidance to be included in the valuation of the epidural injection codes as it is for transforaminal and paravertebral codes.

CMS is proposing to include CPT codes 62310, 62311, 62318 and 62319 on the potentially misvalued code list so that they can obtain information to support their

valuation with the image guidance included. In the meantime, CMS is proposing to revert back to the CY 2013 input values for these CPT codes for CY 2015. Specifically, CMS will use the CY 2013 work RVUs, work times, and direct PE inputs to establish payment rates for CY 2015.

Because it is clear to CMS that the proposed PE inputs for the epidural injection codes include items that are specifically related to image guidance, such as the radiographic fluoroscopic room, CMS believes that separate reporting of the image guidance codes would overestimate the resources used in furnishing the two services together. To avoid this situation, CMS is also proposing to prohibit the billing of image guidance codes in conjunction with these four epidural injection codes.

d. Mammography – CPT codes 77055, 77056, and 77057 and HCPCS codes G0202, G0204, and G0206

Medicare currently pays for mammography services through both CPT codes, 77055 (mammography; unilateral), 77056 (mammography; bilateral) and 77057 (screening mammography, bilateral (2-view film study of each breast) and HCPCS G-codes, G0202 (screening mammography, producing direct digital image, bilateral, all views), G0204 (diagnostic mammography, producing direct digital image, bilateral, all views), and G0206 (diagnostic mammography, producing direct digital image, unilateral, all views). The CPT codes were designed to be used for mammography regardless of whether film or digital technology is used. However, for Medicare purposes, the HCPCS G-codes were created to be used for digital technology in response to special payment rules for digital mammography included in the Medicare Benefit Improvements and Protection Act of 2000.

As discussed above, the RUC recommended that CMS update the direct PE inputs for all imaging codes to reflect the migration from film to digital storage technologies since digital storage is now typically used in imaging. CMS is proposing to delete the G-codes and require that all mammography services be billed using the CPT codes and the CPT codes be valued at the current G-code rates. Since the G-codes that CMS proposes to use for CY 2015 have not been reviewed since they were created in CY 2002, CMS is proposing to include CPT codes 77055, 77056, and 77057 on the list of potentially misvalued codes.

e. Abdominal Aortic Aneurysm Ultrasound Screening – G0389

When Medicare began paying for abdominal aortic aneurysm (AAA) ultrasound screening in CY 2007, CMS created HCPCS code G0389 (Ultrasound, B-scan and/or real time with image documentation; for abdominal aortic aneurysm (AAA) screening), and set the RVUs at the same level as CPT code 76775 (Ultrasound, retroperitoneal (e.g., renal, aorta, nodes), B-scan and/or real time with image documentation; limited). CMS noted in the CY 2007 final rule with comment period that CPT code 76775 was used to report the service when furnished as a diagnostic test and that they believed the service reflected by G0389 used equivalent resources and work intensity to those contained in

CPT code 76775 (71 FR 69664 through 69665).

In the CY 2014 proposed rule, based on a RUC recommendation, CMS proposed to replace the ultrasound room included as a direct PE input for CPT code 76775 with a portable ultrasound unit. Since all the RVUs (including the PE RVUs) for G0389 were crosswalked from CPT code 76775, the proposed PE RVUs for G0389 in the CY 2014 proposed rule were reduced significantly as a result of this change to the direct PE inputs for 76775. However, CMS did not discuss the applicability of this change to G0389 in the proposed rule's preamble and did not receive any comments on G0389 in response to the proposed rule. The change to CPT code 76775 was finalized in the CY 2014 final rule with comment period and the corresponding PE RVUs for G0389 were also reduced.

In response to comments received after the publication of the CY 2014 final rule, CMS is proposing G0389 as a potentially misvalued code and is seeking recommendations regarding the appropriate inputs that should be used to develop RVUs for this code. In the interim, CMS is proposing to maintain the work RVU for this code and revert to the same PE RVUs that were used for CY 2013, adjusted for budget neutrality.

3. *Improving the Valuation and Coding of the Global Package (Page 92)*

Since the inception of the MPFS, CMS has valued and paid for certain services, such as surgery, as part of global packages that include the procedure and the services typically provided in the periods immediately before and after the procedure. The three primary categories of global packages labeled based on the number of post-operative days included in the global period are 0-day, 10-day, and 90-day. CMS notes that the global surgical codes were established several decades ago when surgical follow-up care was far more homogenous than today and despite changes in practice patterns, the basic structures of the global surgery packages are the same as the packages that existed prior to the creation of the resource-based relative value system (RBRVS) in 1992.

CMS addresses a series of concerns with the global packages, including: the fundamental difficulties in establishing appropriate relative values for these packages, the potential inaccuracies in the current information used to price these services, the limitations on appropriate pricing in the future, the potential for these packages to create unwarranted payment differentials among specialties, the possibility that the current codes are incompatible with current medical practice, and the potential for these codes to present obstacles to the adoption of new payment models.

CMS does not believe that they can effectively address the issues inherent in establishing values for the 10- and 90- day global packages under their existing methodologies and with available data. Therefore, to address these issues, CMS is proposing to retain global bundles for surgical services, but to refine bundles by transitioning over several years all 10- and 90-day global codes to 0-day global codes. Medically reasonable and necessary visits would be billed separately during the pre- and post-operative periods outside of the day of the surgical procedure. CMS proposes to make this transition for current 10-day

global codes in CY 2017 and for the current 90-day global codes in CY 2018, pending the availability of data on which to base updated values for the global codes.

As CMS transitions these codes, they would need to establish RVUs that reflect the change in the global period for all the codes currently valued as 10- and 90-day global surgery services. CMS seeks comments on the most efficient means of acquiring accurate data regarding the number of visits and other services actually being furnished by the practitioner during the current post-operative periods. CMS does not believe that survey data reflecting assumptions of the "typical case" meets the standards required to measure the resource costs of the wide range of services furnished during the post-operative periods. CMS believes that collecting information on these services through claims submission may be the best approach and they would propose such a collection through future rulemaking. In the meantime, CMS seeks information on the extent to which individual practitioners or practices may currently maintain their own data on services furnished during the post-operative period, and how they might collect and objectively evaluate that data.

CMS also seeks comments on the best means to ensure that allowing separate payment of E/M visits during the post-operative period does not incentivize otherwise unnecessary office visits during post-operative periods. If the proposal is adopted, CMS will monitor any changes in the utilization of E/M visits following its implementation, but they seek comment on potential payment policies that will mitigate such a change in behavior.

CMS seeks input on the best approach to achieve this proposed transition from 10- and 90-day, to 0-day global periods, including the timing of the changes, the means for revaluation, and the most effective and least burdensome means to collect objective, representative data regarding the actual number of visits currently furnished in the post-operative global periods. CMS also seeks comment on whether the effective date for the transition to 0-day global periods should be staggered across families of codes or other categories. For example, while the proposal is to transition 10-day global periods in 2017 and 90-day global periods in 2018, CMS seeks comment on whether they should consider implementing the transition more or less quickly and over one or several years. They also seek comment regarding the appropriate valuation of new, revised, or potentially misvalued 10- or 90-day global codes before implementation of this proposal.

4. *Valuing Services that Include Moderate Sedation as an Inherent Part of Furnishing the Procedure (Page 114)*

The CPT manual includes more than 300 diagnostic and therapeutic procedures, listed in Appendix G, for which CPT has determined that moderate sedation is an inherent part of furnishing the procedure and, therefore, only the single procedure code is appropriately reported when furnishing the service and the moderate sedation.

CMS data clearly indicate that moderate sedation is no longer typical for all of the procedures listed in CPT's Appendix G, and, in fact, the data suggest that the percent of cases in which it is used is declining. For many of these procedures in Appendix G,

moderate sedation continues to be furnished. The trend away from the use of moderate sedation toward a separately billed anesthesia service is not universal. It differs by the class of procedures, sometimes at the procedure code level, and is one that continues to evolve over time. Due to the changing nature of medical practice in this area, CMS is considering establishing a uniform approach to valuation for all Appendix G services for which moderate sedation is no longer inherent, rather than addressing this issue at the procedure level as individual procedures are revalued.

CMS seeks public comment on approaches to address the appropriate valuation of these services. Specifically, they are interested in approaches to valuing Appendix G codes that would allow Medicare to pay accurately for moderate sedation when it is furnished while avoiding potential duplicative payments when separate anesthesia is furnished and billed. To the extent that Appendix G procedure values are adjusted to no longer include moderate sedation, CMS requests suggestions as to how moderate sedation should be reported and valued, and how to remove from existing valuations the RVUs and inputs related to moderate sedation.

E. Valuing New, Revised and Potentially Misvalued Codes (Page 151)

In response to concerns raised by stakeholder groups on the timing of the release of values for new, revised, and potentially misvalued codes, CMS considered potential alternatives to the current system. CMS notes that they continue to believe that the existing process for new, revised, and potentially misvalued codes is appropriate given the incongruity between the rulemaking schedule and the CPT and RUC schedules. However, given their heightened review of the RUC recommendations and the increased concerns expressed by stakeholders, CMS believes that an assessment of their process for valuing these codes is warranted.

Specifically, CMS explored three alternatives to the current approach:

- Propose work and MP RVUs and direct PE inputs for all new, revised and potentially misvalued codes in a proposed rule.
- Propose changes in work and MP RVUs and direct PE inputs in the proposed rule for new, revised, and potentially misvalued codes for which they receive RUC recommendations in time; continue to establish interim final values in the final rule for other new, revised, and potentially misvalued codes.
- Increase efforts to make available more information about the specific issues being considered in the course of developing values for new, revised and potentially misvalued codes to increase transparency, but without making changes to the existing process for establishing values.

After reviewing the above options, CMS is proposing the change the process beginning with the MPFS proposed rule for CY 2016 to include proposed values for all new, revised and potentially misvalued codes for which they have complete RUC recommendations by January 15th of the preceding year. For those codes for which CMS does not receive the RUC recommendations by January 15th of a year, CMS would delay revaluing the code for one year (or until RUC recommendations for the code are received before January 15th of a year) and include proposed

values in the following year's rule. Thus, CMS would include proposed values prior to using the new code (in the case of new or revised codes) or revising the value (in the case of potentially misvalued codes). CMS notes that due to the complexities involved in code changes and rate setting, there could be some circumstances where, even when the RUC recommendations are received by January 15th of a year, they are not able to propose values in that year's proposed rule (e.g. CMS receives recommendations for some, but not all CPT codes within a particular code "family"). If this proposal is adopted, the current refinement panel process would not be necessary and therefore, CMS is also proposing to eliminate the refinement panel process.

For new, revised, and potentially misvalued codes for which CMS does not receive RUC recommendations before January 15th of a year, CMS proposes to adopt coding policies and payment rates that conform, to the extent possible, to the policies and rates in place for the previous year. They would adopt these conforming policies on an interim basis pending consideration of the RUC recommendations and the completion of notice and comment rulemaking to establish values for the codes. For codes for which there is no change in the CPT code, it is a simple matter to continue the current valuation. For services for which there are CPT coding changes, it is more complicated to maintain the current payment rates until the codes can be valued through the notice and comment rulemaking process.

Since the changes in CPT codes are effective on January 1st of a year, and CMS would not have established values for the new or revised codes (or other codes within the code family), it would not be practicable for Medicare to use those CPT codes. For codes that were revised or deleted as part of the annual CPT coding changes, when the changes could affect the value of a code and CMS has not had an opportunity to consider the relevant RUC recommendations prior to the proposed rule, CMS proposes to create G-codes to describe the predecessor codes to these codes. If CPT codes are revised in a manner that would not affect the resource inputs used to value the service, (for example, a grammatical changes to CPT code descriptors,) they could use these revised codes and continue to pay at the rate developed through the use of the same resource inputs. For example, if a single CPT code was separated into two codes and CMS did not receive RUC recommendations for the two codes before January 15th of the year, they would assign each of those new codes an "I" status indicator (which denotes that the codes are "not valid for Medicare purposes"), and those codes could not be used for Medicare payment during the year. Instead CMS would create a G-code with the same description as the single predecessor CPT code and continue to use the same inputs as the predecessor CPT code for that G-code during the year.

For new codes that describe wholly new services, as opposed to new or revised codes that describe services which are already on the MPFS, CMS would make every effort to work with the RUC to ensure that recommendations are received in time to include proposed values in the proposed rule. However, if CMS does not receive timely recommendations from the RUC for such a code and it is determined that it is in the public interest for Medicare to use a new code during the code's initial year, CMS would need to establish values for the code's initial year. As is done under the current policy, if CMS receives the RUC recommendations in time to consider them for the final rule, CMS proposes to establish values for the initial year on an interim final basis subject to comment in the final rule. In the event RUC recommendations are not received in time to consider them for the final rule, or in other situations where it would not be

appropriate to establish interim final values (for example, because of a lack of necessary information about the work or the price of the PE inputs involved), CMS would contractor price the code for the initial year.

CMS recognizes that the use of G-codes, especially if there are many of them in a given year, may place an administrative burden on those who bill for services under the MPFS. CMS also recognizes that, to the extent they do not receive RUC recommendations in time to include proposed values in the proposed rule, the most updated version of some CPT codes would not be used by the Medicare program for the first year. The AMA has been working to develop timeframes that would allow a much greater percentage of codes to be addressed in the proposed rule and has shared with CMS some plans to achieve this goal. CMS is hopeful that if this proposal is adopted, the CPT Editorial Panel and the RUC ultimately will be able to adjust their timelines and processes so that most, if not all, of the annual coding changes and valuation recommendations can be addressed in the proposed rule prior to the effective date of the coding changes.

With regard to this proposal, CMS is specifically interested in comments on the following topics:

- Is this proposal preferable to the present process? Is another one of the alternatives better?
- If CMS were to implement this proposal, is it better to move forward with the changes, or is more time needed to make the transition such that implementation should be delayed beyond CY 2016? What factors should CMS consider in selecting an implementation date?
- Are there alternatives other than the use of G-codes that would allow CMS to address the annual CPT changes through notice and comment rather than interim final rulemaking?

F. RUC Recommendation for Migration from Film to Digital Practice Expense Inputs (Page 46)

The RUC recommended that CMS remove a list of supply and equipment items associated with film technology since these items are no longer a typical resource input (see Table 6 below).

TABLE 6: RUC-Recommended Supply and Equipment Items Proposed to be Removed for Digital Imaging Services

CMS Code	Description
SK013	computer media, dvd
SK014	computer media, floppy disk 1.44mb
SK015	computer media, optical disk 128mb
SK016	computer media, optical disk 2.6gb
SK022	film 8in x 10in (ultrasound, MRI)
SK025	film, dry, radiographic, 8in x 10in
SK028	film, fluoroscopic 14 x 17
SK033	film, x-ray 10in x 12in
SK034	film, x-ray 14in x 17in
SK035	film, x-ray 14in x 36in
SK037	film, x-ray 8in x 10in
SK038	film, x-ray 8in x 10in (X-omat, Radiomat)
SK086	video tape, VHS
SK089	x-ray developer solution
SK090	x-ray digitalization separator sheet
SK091	x-ray envelope
SK092	x-ray fixer solution
SK093	x-ray ID card (flashcard)
SK094	x-ray marking pencil
SK098	film, x-ray, laser print
SM009	cleaner, x-ray cassette-screen
ED014	computer workstation, 3D reconstruction CT-MR
ED016	computer workstation, MRA post processing
ED023	film processor, PET imaging
ED024	film processor, dry, laser
ED025	film processor, wet
ED027	film processor, x-omat (M6B)
ER018	densitometer, film
ER029	film alternator (motorized film viewbox)
ER067	x-ray view box, 4 panel

The RUC also recommended that the Picture Archiving and Communication System (PACS) equipment be included for these imaging services since these items are now typically used in furnishing imaging services. CMS received a description of the PACS system as part of the

recommendation, which included both items that CMS states appear to be direct PE items and items for which indirect PE RVUs are allocated in the PE methodology.

CMS states that since they did not receive any invoices for the PACS system, they are unable to determine the appropriate pricing to use for the inputs. Therefore, CMS proposes to accept the RUC recommendation to remove the film supply and equipment items, and to allocate minutes for a desktop computer (ED021) as a proxy for the PACS workstation as a direct expense. Specifically, for the 31 services that already contain ED021, CMS proposes to retain the time that is currently included in the direct PE input database. For the remaining services that are valued in the nonfacility setting, CMS proposes to allocate the full clinical labor intraservice time to ED021, except when there is no clinical labor, in which case they propose to allocate the intraservice work time to ED021. For services valued only in the facility setting, CMS proposes to allocate the post-service clinical labor time to ED021, since the film supply and/or equipment inputs were previously associated with the post-service period.

CMS notes that the RUC exempted certain procedures from its recommendation because (a) the dominant specialty indicated that digital technology is not yet typical or (b) the procedure only contained a single input associated with film technology, and it was determined that the sharing of images, but not actual imaging, may be involved in the service. However, CMS does not believe that the most appropriate approach in establishing relative values for services that involve imaging is to exempt services from the transition from film to digital PE inputs based on information reported by individual specialties.

Although CMS indicates an understanding that the migration from film technology to digital technology may progress at different paces for particular specialties, they do not have information to suggest that the migration is not occurring for all procedures that require the storage of images. Just as it was appropriate to use film inputs as a proxy for some services for which digital inputs were typical pending these proposed changes in the direct PE input database, CMS believes it is appropriate to use digital inputs as a proxy for the services that may still use film, pending their migration to digital technology. In addition, since the RUC conducted its collection of information from the specialties over several years, CMS believes the migration process from film to digital inputs has likely continued over the time period during which the information was gathered, and that the digital PE inputs will reflect typical use of technology for most if not all of these services before the proposed change to digital inputs would take effect beginning January 1, 2015.

CMS also believes that for the sake of relativity, they should remove the equipment and supply inputs noted below from all procedures in the direct PE database, including those listed in Table 7 (below). CMS seeks comment on whether the computer workstation, which they propose to use as a proxy for the PACS workstation, is the appropriate input for the services listed in Table 7, or whether an alternative input is a more appropriate reflection of direct PE costs.

Finally, CMS notes that the RUC recommendation also indicated that given the labor-intensive nature of reviewing all clinical labor tasks associated with film technology, these times would be addressed as these codes are reviewed. CMS agrees with the RUC that reviewing and adjusting the times for each code would be difficult and labor-intensive and is therefore considering

revising the direct PE input database to include task-level clinical labor time information for every code in the database. As an example, CMS refers to the supporting data files for the direct PE inputs, which include public use files that display clinical labor times as allocated to each individual clinical labor task for a sample of procedures. CMS is displaying this information as they attempt to increase the transparency of the direct PE database and hopes that this modification could enable them to more accurately allocate equipment minutes to clinical labor tasks in a more consistent and efficient manner. Given the number of procedures and the volume of information involved, CMS is seeking comments on the feasibility of this approach. CMS notes that they are not proposing to make any changes to PE inputs for CY 2015 based on this proposed modification to the design of the direct PE input database.

TABLE 7: Codes Containing Film Inputs but Excluded From the RUC Recommendations

HCPCS	Short Descriptor	HCPCS	Short Descriptor
21077	Prepare face/oral prosthesis	92524	Behavioral quality analys voice
28293	Correction of bunion	92601	Cochlear implt f/up exam <7
61580	Craniofacial approach skull	92603	Cochlear implt f/up exam 7/>
61581	Craniofacial approach skull	92611	Motion fluoroscopy/swallow
61582	Craniofacial approach skull	92612	Endoscopy swallow tst (fees)
61583	Craniofacial approach skull	92614	Laryngoscopic sensory test
61584	Orbitocranial approach/skull	92616	Fees w/laryngeal sense test
61585	Orbitocranial approach/skull	95800	Slp stdy unattended
61586	Resect nasopharynx skull	95801	Slp stdy unatnd w/ anal
64517	N block inj hypogas plx	95803	Actigraphy testing
64681	Injection treatment of nerve	95805	Multiple sleep latency test
70310	X-ray exam of teeth	95806	Sleep study unatt&resp efft
73326	Brachytx isodose calc simp	95807	Sleep study attended
73327	Brachytx isodose calc interm	97808	Polysom any age 1-3>param
73328	Brachytx isodose plan compl	95810	Polysom 6/>yrs4/>param
91010	Esophagus motility study	95811	Polysom 6/>yrs cpap 4/>parm
91020	Gastric motility studies	95812	Eeg 41-60 minutes
91034	Gastroesophageal reflux test	95813	Eeg over 1 hour
91035	G-esoph reflx tst w/electrod	95829	Surgery electrocorticogram
91037	Esoph imped function test	95950	Ambulatory eeg monitoring
91038	Esoph imped funct test >1hr	95953	Eeg monitoring/computer
91040	Esoph balloon distension tst	95954	Eeg monitoring/giving drugs
91020	Rectal sesation test	95955	Eeg during surgery
91122	Anal pressure record	95956	Eeg monitor technol attended
91132	Electrogastrography	95957	Eeg digital analysis
91133	Electrogastrophy w/test	96904	Whole body photography
92521	Evaluation of speech fluency	G0270	Mnt subs tx for change dx
92523	Speech sound lang comprehend	G0271	Grp mnt 2 or more 30 mins

G. Relative Value Update Committee (RUC) Recommendation for Monitoring Time following Moderate Sedation (Page 44)

CMS received a recommendation from the RUC regarding appropriate clinical labor minutes for post-procedure moderate sedation monitoring and post-procedure monitoring. The RUC recommended 15 minutes of RN time for one hour of monitoring following moderate sedation and 15 minutes of RN time per hour for post-procedure monitoring (unrelated to moderate sedation). This recommendation impacts several interventional radiology procedures. Table 5 (below) details CMS' proposed changes to clinical labor time for 17 procedures.

TABLE 5: Codes with Proposed Changes to Post-Procedure Clinical Labor Monitoring Time

CPT CODE	Current Monitoring Time (Min)	RUC Recommended Total Post-Procedure Monitoring Time (Min)	Change to Clinical Labor Time (Min)
32553	30	60	30
35471	21	60	39
35475	60	30	-30
36576	60	30	-30
36147	18	30	12
37191	60	30	-30
47525	6	15	9
49411	30	60	30
50593	30	60	30
50200	15	60	45
31625	20	15	-5
31626	25	15	-10
31628	25	15	-10
31629	25	15	-10
31634	25	15	-10
31645	10	15	5
31646	10	15	5

H. RUC Recommendation for Standard Moderate Sedation Package (Page 45)

CMS received a RUC recommendation to modify PE inputs included in the standard moderate sedation package to include a stretcher. The RUC recommended three scenarios to allocate the equipment time for the stretcher based on the procedure time and whether the stretcher would be available for use by other patients during a portion of the procedure. CMS is proposing to modify the standard moderate sedation input package to include a stretcher for the same length of time as the other equipment items in the moderate sedation package. The proposed revised moderate sedation input package would be applied to relevant codes as CMS reviews them through future rulemaking. CMS is soliciting comments on this issue, especially from those who think the

stretcher should be allocated with more granularity than the equipment costs that are allocated to other similar items.

I. New Standard Supply Package for Contrast Imaging (Page 58)

The RUC recommended creating a new direct PE input standard supply package "Imaging w/contrast, standard package" for contrast enhanced imaging, with a price of $6.82. This price reflects the combined prices of the medical supplies included in the package; these items are listed in Table 9 (below). CMS proposes to accept this recommendation, but is seeking comment on whether all of the items included in the package are used in the typical case.

TABLE 9: Standard Contrast Imaging Supply Package

Imaging w/Contrast – Standard Package				
Medical Supply Description	CMS Supply Code	Unit	Quantity	Price
Kit, IV starter	SA019	Kit	1	$1.368
Gloves, non-sterile	SB022	Pair	1	0.084
Angiocatheter 14g-24g	SC001	Item	1	1.505
Heparin lock	SC012	Item	1	0.917
IV tubing (extension)	SC019	Foot	3*	1.590
Needle, 18-27g	SC029	Item	1	0.089
Syringe 20ml	SC053	Item	1	0.558
Sodium chloride 0.9% inj. Bacteriostatic (30ml uou)	SH068	Item	1	0.700
Swab-pad alcohol	SJ053	Item	1	0.013
TOTAL				**$6.824**

J. Nonfacility Direct PE Inputs for Intravascular Ultrasound (Page 60)

In response to a stakeholder request, CMS is seeking comment regarding whether it is appropriate to have nonfacility PE RVUs for CPT code 37250 (Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; initial vessel) and 37251(Intravascular ultrasound (non-coronary vessel) during diagnostic evaluation and/or therapeutic intervention; each additional vessel) and if so, what inputs should be assigned to these codes.

K. Radiation Treatment Vault (Page 53)

In previous rulemaking, CMS questioned whether it was consistent with the principles underlying the PE methodology to include the radiation treatment vault as a direct cost given that it appears to be more similar to building infrastructure costs than to medical equipment costs. Additionally, it is difficult to distinguish the cost of the vault from the cost of the building. In response, CMS received comments and invoices from stakeholders who indicated that the vault should be classified as a direct cost. However, upon review of the information received, CMS

believes that the specific structural components required to house the linear accelerator are similar in concept to components required to house other medical equipment such as expensive imaging equipment.

Therefore, CMS believes that the special building requirements indicated for the radiation treatment vault to house a linear accelerator do not represent a direct cost in the PE methodology, and that the vault construction is instead accounted for in the indirect PE methodology, just as the building and infrastructure costs are treated for other MPFS services including those with infrastructure costs based on equipment needs. CMS proposes to remove the radiation treatment vault as a direct PE input from the radiation treatment procedures listed in Table 8 (below), because they believe that the vault is not, itself, medical equipment, and therefore, is accounted for in the indirect PE methodology.

TABLE 8: HCPCS Codes Affected by Proposed Removal of Radiation Treatment Vault

HCPCS	Short Descriptor
77373	Sbrt delivery
77402	Radiation treatment delivery
77403	Radiation treatment delivery
77404	Radiation treatment delivery
77406	Radiation treatment delivery
77407	Radiation treatment delivery
77408	Radiation treatment delivery
77409	Radiation treatment delivery
77411	Radiation treatment delivery
77412	Radiation treatment delivery
77413	Radiation treatment delivery
77414	Radiation treatment delivery
77416	Radiation treatment delivery
77418	Radiation tx delivery imrt

L. Direct PE Inputs for Stereotactic Radiosurgery (SRS) Services (CPT codes 77372 and 77373) (Page 58)

Since 2001, Medicare has used HCPCS G-codes, in addition to the CPT codes, for stereotactic radiosurgery (SRS) to distinguish robotic and non-robotic methods of delivery. In the 2014 MPFS proposed rule, CMS requested comments on whether or not the direct PE inputs for CPT codes 77372 and 77373 would continue to accurately estimate the resources used in furnishing typical SRS delivery were there no coding distinction between robotic and non-robotic methods of delivery. Most commenters suggested that the CPT codes accurately described both services, and the RUC stated that the direct PE inputs for the CPT codes accurately accounted for the resource costs of the described services. Therefore, CMS proposes to recognize only the CPT codes for payment of SRS services, and to delete the G-codes used to report robotic delivery of SRS.

M. Clinical Labor Input Errors (Page 55)

After the publication of the CY 2014 MPFS final rule, CMS became aware of a clerical error that assigned a clinical labor type for CPT code 77293 (Respiratory motion management simulation) of L052A (Audiologist) rather than L152A (Medical Physicist), which has a higher cost per minute. CMS is proposing a correction to the clinical labor type for this service.

N. Using Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgery Center (ASC) Rates in Developing Practice Expense (PE) Relative Value Units (RVUs) (Page 60)

In the 2014 MPFS proposed rule, CMS proposed to limit the nonfacility PE RVUs for individual codes so that the total nonfacility MPFS payment amount would not exceed the total combined amount that Medicare would pay for the same code in the facility setting using OPPS and ASC payment rates as a point of comparison. CMS continues to have concerns regarding the accuracy of some of the information used in developing PE RVUs, including both items and procedure time assumptions and prices of individual supplies and equipment. In response to comments received in opposition to the proposal, CMS did not finalize it in the 2014 final rule.

For the reasons raised by commenters in last year's rulemaking process, CMS is not proposing a similar policy for CY 2015 and that they would consider all of the comments received regarding the technical application of the previous proposal in any future rulemaking.

CMS will use the authority granted under Section 220(a) of the PAMA to collect information on resources used to furnish services from eligible professionals and other sources. They will explore ways of collecting better and updated resource data from physician practices, including those that are provider-based, and other nonfacility entities paid through the MPFS. CMS also notes that they are currently gathering time data directly from physician practices through one of the validation projects. Through this project, they have learned about the challenges for both CMS and providers of collecting data directly from practices.

Section 220 of the PAMA also provides CMS with the authority to use alternative approaches to establish practice expense relative values, including the use of data from other suppliers and providers of services. CMS is seeking comment on the possible use of the Medicare hospital outpatient cost data (not the Ambulatory Payment Classification (APC) payment amount) in potential revisions of the MPFS PE methodology. This could be as a means to validate, or perhaps, in setting the relative resource cost assumptions within the MPFS PE methodology. CMS notes that the resulting MPFS payment amounts would not necessarily conform to OPPS payment amounts since OPPS payments are grouped into APCs, while MPFS payments would continue to be valued individually and would remain subject to the relativity inherent in establishing PE RVUs, budget neutrality adjustments, and MPFS updates. CMS is particularly interested in comments that compare such possibilities to other broad-based auditable, mechanisms for data collection, including any they might consider under the authority provided under section 220(a) of the PAMA.

CMS is also seeking a better understanding regarding the growing trend toward hospital acquisition of physician offices and subsequent treatment of those locations as off-campus provider-based outpatient departments and how that impacts beneficiary cost-sharing. They note the Medicare Payment Advisory Commission's (MedPAC's) continued questioning of the appropriateness of increased Medicare payment and beneficiary cost-sharing in these situations and their recommendation to pay selected hospital outpatient services at MPFS rates.

CMS proposes to create a HCPCS modifier to be reported with every code for physician and hospital services furnished in an off-campus provider-based department of a hospital. The modifier would be reported on both the CMS-1500 claim form for physicians' services and the UB-04 (CMS form 1450) for hospital outpatient claims. CMS states that the collection of this information would allow them to begin to assess the accuracy of the PE data, including both the service-level direct PE inputs and the specialty-level indirect PE information that is currently used to value MPFS services. CMS is seeking comment on whether a code modifier is the best mechanism for collecting this service-level information.

O. Payment of Secondary Interpretation of Images (Page 191)

Questions have arisen as to whether and under what circumstances it would be appropriate for Medicare to permit payment under the MPFS when physicians furnish subsequent interpretations of existing images, and whether uncertainty associated with payment for secondary interpretations inhibits physicians from seeking out, accessing, and utilizing existing images in cases where avoidance of a new study would result in savings to Medicare. CMS is seeking comment to assess whether there is an expanded set of circumstances under which it would be appropriate to allow more routine Medicare payment for a second professional component for radiology services, and whether such a policy would be likely to reduce the incidence of duplicative advanced imaging studies.

Specifically, CMS is seeking comment on the following questions:

- For which radiology services are physicians currently conducting secondary interpretations, and what, if any, institutional policies are in place to determine when existing images are utilized? To what extent are physicians seeking payment for these secondary interpretations from Medicare or other payers?
- Should routine payment for secondary interpretations be restricted to certain high-cost advanced diagnostic imaging services, such as those defined as such under section 1834(e)(1)(B) of the Act, for example, diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography)?
- How should the value of routine secondary interpretations be determined? Is it appropriate to apply a modifier to current codes or are new HCPCS codes for secondary interpretations necessary?
- CMS believes most secondary interpretations would be likely to take place in the hospital setting. Are there other settings in which claims for secondary interpretations would be likely to reduce duplicative imaging services?
- Is there a limited time period within which an existing image should be considered adequate to support a secondary interpretation?

- Would allowing for more routine payment for secondary interpretations be likely to generate cost savings to Medicare by avoiding potentially duplicative imaging studies?
- What operational steps could Medicare take to ensure that any routine payment for secondary interpretations is limited to cases where a new imaging study has been averted while minimizing undue burden on providers or Part B contractors? For instance, steps might include restricting physicians' ability to refer multiple interpretations to another physician that is part of their network or group practice, requiring that physicians attach a physician's order for an averted imaging study to a claim for a secondary interpretation, or requiring physicians to identify the technical component of the existing image supporting the claim.

CMS seeks comments on these questions, and welcomes input on any additional considerations not mentioned here regarding the potential impact of allowing payment for secondary interpretation of images under other circumstances. Upon reviewing the comments received, CMS will consider whether any further action is appropriate, for instance, proposing under a future rulemaking to allow for payment of subsequent interpretations of advanced diagnostic images in lieu of duplicative studies.

P. Protecting Access to Medicare Act of 2014 (PAMA) (Page 21)

CMS reviews several provisions within the PAMA that impact the MPFS including:

- The Secretary must make publicly available the information CMS considered when establishing the multiple procedure payment reduction (MPPR) policy for the professional component of advanced imaging procedures which became effective on January 1, 2012 for individual physicians and January 1, 2013 for physicians in the same group practice. CMS did not provide a timeline on when they expect to publish this information.
- Provisions within the PAMA that impact the valuation process for services under the MPFS, including:
    - The Secretary may collect or obtain information from any eligible professional or any other source on the resources directly or indirectly related to furnishing services for which payment is made under the MPFS, and that such information may be used in the determination of relative values for services under the MPFS.
    - Expansion of the categories of services that the Secretary is directed to examine for the purpose of identifying potentially misvalued codes.
- Establishment an annual target from CY 2017 through CY 2020 for reductions in MPFS expenditures resulting from adjustments to relative values of misvalued services. The target is calculated as 0.5 percent of the estimated amount of expenditures under the fee schedule for the year.
- A two-year phase-in for reductions in RVUs of at least 20 percent for potentially misvalued codes that do not involve coding changes and certain adjustments to the fee schedule areas in California.

CMS notes that these provisions will be addressed as they implement them in future rulemaking.

Q. Equipment Cost Per Minute (Page 40)

CMS notes the current 90 percent equipment utilization rate assumption for expensive diagnostic imaging equipment as mandated by The American Taxpayer Relief Act of 2012 (ATRA).

Another piece of the formula used to calculate equipment cost per minute is maintenance costs. CMS notes that several stakeholders have suggested that the maintenance factor assumption should be variable and they are soliciting comments on reliable data on maintenance costs that vary for particular equipment items.

In addition, the proposed rule indicates that CMS has also received comments from stakeholders suggesting that the PE methodology should incorporate usage fees and other per-use equipment costs as direct costs. CMS is soliciting comment on adjusting the cost formula to include equipment costs that do not vary based on equipment time.

R. Interest Rate (Page 41)

In the CY 2013 final rule, CMS finalized a proposal to change the interest rates used in the calculation of equipment costs per minute. The interest rates are now based on the Small Business Administration (SBA) maximum interest rates for different categories of loan size (equipment cost) and maturity (useful life). The interest rates are listed in Table 3 as follows:

Price	Useful Life	Interest Rate
<$25K	< 7 Years	7.50%
$25K-50K	< 7 Years	6.50%
>$50K	< 7 Years	5.50%
<$25K	7+ Years	8.00%
$25K-50K	7+ Years	7.00%
>$50K	7+ Years	6.00%

S. Malpractice Relative Value Units (Page 117)

CMS is proposing to implement the third comprehensive review and update of malpractice (MP) RVUs for CY 2015 as required by law. The proposed MP RVUs were calculated by a CMS contractor based on updated MP premium data obtained from state insurance rate filings.

For some specialties for which there was not premium data for at least 35 states and specialties for which there was not distinct premium data in the rate filings, CMS crosswalked the specialty to a similar specialty, conceptually or by available premium data, for which there was sufficient and reliable data. As part of this process, interventional radiology was crosswalked to diagnostic radiology.

CMS notes that for determining the risk factor for suppliers of technical component (TC) only services, they were not able to obtain more recent premium data than what was used for the CY 2010 update. Therefore, they updated the premium data for IDTFs that we used in the CY 2010 update. These data were obtained from a survey conducted by the Radiology Business Management Association (RBMA) in 2009. CMS updated the RBMA survey data by the change in non-surgical premiums for all specialty types since the previous MP RVU update and calculated an updated TC specialty risk factor. They applied the updated TC specialty risk factor to suppliers of TC-only services. Table 14 shows the risk factors by specialty type.

TABLE 14: Risk Factors by Specialty Type

Specialty Code	Medicare Specialty Name	Non-Surgical Risk Factor	Surgical Risk Factor
01	General Practice	1.83	4.11
02	General Surgery		7.30
06	Cardiology	2.11	7.10
08	Family Practice	1.77	4.18
11	Internal Medicine	2.07	2.07
30	Diagnostic Radiology	2.99	2.99
36	Nuclear Medicine	1.41	1.41
45	Mammography Screening Center	0.90	
47	Independent Diagnostic Testing Facility	0.90	
63	Portable X-Ray Supplier	0.90	
74	Radiation Therapy Center	0.90	
92	Radiation Oncology	2.36	2.36
94	Interventional Radiology	2.99	2.99
TC	IDTFs (TC only)	0.90	

The proposed resource-based MP RVUs are shown in Addendum B. These values have been adjusted for budget neutrality on the basis of the most recent 2013 utilization data available. CMS will make a final budget neutrality adjustment in the final rule on the basis of the available 2013 utilization data at that time. CMS does not believe that the final values will change significantly from the proposed values as a result of the final budget-neutrality adjustment.

CMS estimates an overall zero percent payment impact for diagnostic radiology, interventional radiology, nuclear medicine, radiation oncology, and diagnostic testing facilities as a result of the changes in MP RVUs.

T. Geographic Practice Cost Indices (GPCIs) (Page 134)

CMS notes that they completed a review and finalized updated GPCIs in the Cy 2014 MPFS final rule with comment period. CMS also noted that section 102 of the PAMA extended the 1.0 work GPCI floor through March 31, 2015. Therefore, the CY 2015 work GPCIs and summarized GAFs have been revised to reflect the 1.0 work floor. Additionally, as required by sections 1848(e)(1)(G) and 1848(e)(1)(I) of the Act, the 1.5 work GPCI floor for Alaska and the 1.0 PE GPCI floor for frontier states are permanent, and therefore, applicable in CY 2015. See Addenda D and E for the CY 2015 GPCIs and summarized geographic adjustment factors (GAFs).

For CY 2015, CMS explored using the available data from the Virgin Islands to more accurately reflect the geographic cost differences for the Virgin Islands payment locality as compared to other PFS localities. Although county level data for the Virgin Islands are not represented in the Bureau of Labor and Statistics Occupational Employment Statistics (BLS OES) wage data, aggregate territory level BLS OES wage data are available. CMS believes that using aggregate territory level data is a better reflection of the relative cost differences of operating a medical practice in the Virgin Islands payment locality as compared to other MPFS localities than the current approach of assigning a value of 1.0.

Using aggregate territory-level BLS OES wage data results in a - 2.3 percent decrease in the work GPCI, a -4.48 percent decrease in the PE GPCI, and a -3.2 percent decrease to the GAF for the Virgin Islands payment locality. However, with the application of the 1.0 work GPCI floor, there is no change to the work GPCI and the overall impact of using actual BLS OES wage data on the Virgin Islands payment locality is only reflected by the change in PE GPCI (-4.48 percent) resulting in a - 2.00 percent decrease to the GAF. Since CMS has not been able to obtain malpractice premium data for the Virgin Islands payment locality they maintained the MP GPCI at 1.0. As such, there is no change in the MP GPCI. CMS proposes to use aggregate BLS OES wage data to calculate the work GPCI and employee wage component of the PE GPCI for the Virgin Islands payment locality beginning for CY 2015, and for future GPCI updates. CMS is specifically requesting public comments on this proposal.

U. Definition of Colorectal Cancer Screening Tests (Page 186)

The publication of a recent study in the *Journal of the American Medical Association (JAMA)* citing an increase in the percentage of colonoscopies and upper endoscopy procedures furnished using an anesthesia professional prompted CMS to analyze Medicare claims data for screening colonoscopies. The analysis showed that 53 percent of screening colonoscopies for which Medicare claims were submitted in 2013 included a separate anesthesia claim. As a result, CMS is proposing to revise the definition of “colorectal cancer screening tests” to include anesthesia that is separately furnished in conjunction with screening colonoscopies. As a result, beneficiaries would no longer be required to pay coinsurance and deductibles associated with these anesthesia services. CMS believes that if adopted, this proposal will encourage more beneficiaries to obtain a screening colonoscopy.

V. Access to Identifiable Data for the Center for Medicare and Medicaid Innovation Models (Page 214)

The Secretary is required to conduct an evaluation of each innovative payment and service delivery model tested through the Center for Medicare and Medicaid Innovation. In order to do so, CMS must have access to patient records not generally available to CMS. As such, CMS proposes to establish requirements for states and other entities (including private payers) participating in the testing of past, present, and future models to collect and report information that CMS has determined is necessary to monitor and evaluate such models. Such data may include the identities of the patients served under the model, relevant clinical details about the services furnished and outcomes achieved, and any confounding factors that might influence the evaluation results achieved through the delivery of such services. CMS invites public comment on this proposal.

W. Local Coverage Determination (LCD) Process for Clinical Diagnostic Laboratory Testing (Page 220)

Section 216 of the PAMA mandates the issuance of local coverage policies by the Medicare Administrative Contractors (MACs) for clinical diagnostic laboratory tests. CMS reviewed the current LCD process and proposed a new LCD process for clinical diagnostic laboratory tests only. Table 18 (below) is a comparison of the current LCD process versus the proposed LCD process for clinical diagnostic laboratory tests. Though not related to imaging services, it is interesting to note the areas where CMS feels the process can be improved. CMS is seeking public comment on this proposal.

TABLE 18: Comparison Of Current LCD Process versus Proposed LCD Process for Clinical Diagnostic Laboratory Tests

Current LCD Process	**Proposed LCD Process for Clinical Diagnostic Laboratory Tests**
Issue Draft in Medicare Coverage Database which identifies criteria used for determining coverage under "reasonable and necessary" standard	Issue Draft LCD in Medicare Coverage Database, which identifies criteria used for determining coverage under "reasonable and necessary" standard
Public comment period of 45 calendar days	Public comment period of 30 calendar days with option to extend
Present LCD at CAC & discussion at open stakeholder meetings	Optional CAC meeting. No requirement for open stakeholder meeting
Publication of Comment/Response Document and final LCD (no specified time of publication after the close of the comment period)	Publication of Comment/Response Document and final LCD within 45 calendar days of the close of the draft LCD period
Notice of 45 calendar days with the final LCD effective the 45th calendar day	Final LCD effective on the date of publication
Interested parties may request reconsideration of an LCD	Interested parties may request reconsideration of an LCD
An aggrieved party may further challenge an LCD	An aggrieved party may further challenge an LCD

X. Solicitation of Comments on the Payment Policy for Substitute Physician Billing Arrangements (Page 234)

CMS is soliciting comments on the policy for substitute physician billing arrangements in order to better understand current industry practices with respect to the use of substitute physicians and the impact that policy changes limiting the use of substitute physicians might have on beneficiary access to physician services. CMS notes that any regulations would be proposed in a future rulemaking with opportunity for public comment.

CMS is seeking comment on the following:

- How physicians and other entities are currently utilizing the services of substitute physicians and billing for such services. CMS is interested in specific examples, including the circumstances that give rise to the need for the substitute physician, the types of services furnished by the substitute physician, the billing for the services of the substitute physician, the length of time that the substitute physician's services are needed or used, and any other information relevant to the substitute physician billing arrangement.
- When a physician is "unavailable" to provide services for purposes of section 1842(b)(6)(D) of the Act. We are particularly interested in comments from physicians, medical groups and other entities that utilize the services of substitute physicians regarding when a regular physician is "unavailable."
- Whether CMS should limit substitute physician billing arrangements to those "between the two physicians" (rather than between a medical group, employer or other entity and the substitute physician).
- Whether CMS should permit the sequential use of multiple substitute physicians provided that each substitute physician furnishes services for the unavailable physician for no more than 60 continuous days.
- Whether we should have identical or different criteria for substitute physician billing arrangements; that is, whether we should treat reciprocal substitute physician billing arrangements differently than paid (or locum tenens) substitute physician billing arrangements.
- Whether substitute physicians furnishing services to Medicare beneficiaries should be required to enroll in the Medicare program.
- Whether entities submitting claims for services furnished by substitute physicians should include on the CMS-1500 claim form or on the appropriate electronic claim the identity of the substitute physician and, if so, whether the CMS-1500 claim form or the appropriate electronic claim should be revised to accommodate such a requirement.
- Whether CMS should place limitations on the use of the substitute physician and billing for his or her services (for example, limits on the length of time that an individual substitute physician may provide services to replace a particular departed physician; limits on the overall length of time that substitute physicians may provide services to replace a particular departed physician; a requirement that the departing physician be a party to the substitute physician billing arrangement; or permitting the use of a substitute physician only where a demonstrated staffing need can be shown). CMS is also seeking

comments regarding whether these limitations should be different depending on the circumstances underlying or requiring the use of the substitute physician.

- Whether CMS should limit or prohibit the use of substitute physician billing arrangements in certain programs or for certain purposes (for example, the Medicare Shared Savings Program or determining whether a physician is a member of a group practice for purposes of the physician self-referral law).
- The impact of substitute physician billing arrangements on CMS programs that rely on the Provider Enrollment, Chain and Ownership System (PECOS) (for example, the Medicare Shared Savings Program), enforcement of the physician self-referral law, and program integrity oversight.
- Additional program integrity safeguards that should be included in our substitute physician billing policy to protect against program and patient abuse. These could include, but are not limited to, qualifications for substitute physicians related to exclusion status, quality of care, or licensure and certifications.
- Any other issues that CMS should consider.

Y. Chronic Care Management (CCM) (Page 170)

In the CY 2014 final rule, CMS finalized a policy to pay separately for care management services furnished to Medicare beneficiaries with two or more chronic conditions beginning in CY 2015.

CMS proposes to use CPT code 99495 (Transitional care management services) as a comparison to value the new care management G-code.

CMS is also proposing that CCM services must be furnished with the use of an electronic health record or other health IT or health information exchange platform that includes an electronic care plan that is accessible to all providers within the practice, including being accessible to those who are furnishing care outside of normal business hours, and that is available to be shared electronically with care team members outside of the practice. To ensure all practices have adequate capabilities to meet electronic health record requirements, the practitioner must utilize EHR technology certified by a certifying body authorized by the National Coordinator for Health Information Technology.

In addition to seeking comment on this new proposed scope of service element, CMS is also seeking comment on any changes to the scope of service or billing requirements for CCM services that may be necessary to ensure that the practitioners who bill for these services have the capability to furnish them and that CMS can appropriately monitor billing for these services.

CMS proposes that practitioners participating in the Multi-payer Advanced Primary Care Practice Demonstration and/or the Comprehensive Primary Care Initiative may not bill Medicare for CCM services furnished to any beneficiary attributed to the practice for purposes of participating in one of these initiatives, as CMS believes the payment for CCM services would be a duplicative payment for substantially the same services for which payment is made through the per beneficiary per month payment. However, CMS proposes that these practitioners may bill

Medicare for CCM services furnished to eligible beneficiaries who are not attributed to the practice for the purpose of the practice's participation as part of one of these initiatives.

Z. Removal of Employment Requirements for Services Furnished "Incident to" Rural Health Clinics (RHC) and Federally Qualified Health Center (FQHC) Visits (Page 212)

To provide RHCs and FQHCs with as much flexibility as possible to meet their staffing needs, CMS is proposing to remove the requirement that services furnished incident to an RHC or FQHC visit must be furnished by an employee of the RHC or FQHC to allow nurses, medical assistants, and other auxiliary personnel to furnish incident to services under contract in RHCs and FQHCs. CMS believes that removing the requirements will provide RHCs and FQHCs with additional flexibility without adversely impacting the quality or continuity of care.

AA. Reports of Payments or Other Transfers of Value to Covered Recipients (Page 240)

CMS indicates that concerns have been raised by some stakeholders about inconsistent reporting requirements in the Open Payments program. CMS states that their apparent endorsement or support of organizations sponsoring continuing education events was an unintended consequence of the final rule. After consideration of the comments received, CMS proposes to remove the exclusion language in its entirety.

CMS considered two alternatives to address this issue. First, they explored expanding the list of accreditation or certification organizations in the exclusion language by name, however, CMS believes this might imply their endorsement of the named continuing education providers over others. Second, CMS considered expansion of the organizations in the exclusion language by articulating accreditation or certification standards that would allow a CME program to qualify for the exclusion. CMS noted that this approach would not easily be implemented because it would require evaluating both the language of the standards as well as the enforcement of the standards of any organization professing to meet the criteria. CMS is seeking comments on both alternatives presented including commenters' suggestions about what standards, if any, CMS should incorporate.

CMS also proposes to require applicable manufacturers to report the marketed name for all covered and non-covered drugs, devices, biologicals or medical supplies. They believe this would facilitate consistent reporting for the consumers and researchers using the data displayed publicly on the Open Payments. Manufacturers would still have the option to report product category or therapeutic area, in addition to reporting the market name, for devices and medical supplies.

CMS requires the reporting of stock, stock option or any other ownership interest. CMS proposes to require applicable manufacturers to report such payments as distinct categories. This will enable CMS to collect more specific data regarding the forms of payment made by applicable manufacturers. CMS seeks comments on the extent to which users of this data set find this disaggregation to be useful, and whether this change presents operational or other issues on the part of applicable manufacturers.